Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
COTULLA EMS

Respondent Name
TEXAS MUTUAL INSURANCE COMPANY

MFDR Tracking Number
M4-14-3717-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
August 22, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "A0998 is the correct code for Ambulance Response NO TRANSPORT, not only the correct code but the only code to use for a NON TRANSPORT. . . . Cotulla was the first Emergency crew to arrive on scene and treat patient until flight crew arrived. Cotulla EMS administered IV with fluids and placed patient in spinal immobilization prior to air ambulance arrival. Patient was being air lifted for MVA Treatment . . . patient care is transport to Air flight EMS crew for transport to San Antonio trauma center. . . . We ask that you review claim dispute and send payment for service rendered to patient . . ."

Amount in Dispute: $119.05

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor provider onsite EMS services to the claimant until he was airflighted for further treatment. The requestor billed a code that cannot be paid, A0998SS, because Medicare uses another code for reporting and payment. Absent the different code, no payment is due."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 20, 2013	Procedure Code A0998	$119.05	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.10 sets out requirements related to medical billing forms and formats.
3. 28 Texas Administrative Code §133.20 sets out medical bill submission procedures for health care providers.
4. 28 Texas Administrative Code §133.210 sets out documentation requirements.
5. 28 Texas Administrative Code §134.1 sets forth general provisions related to medical reimbursement.
6. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.

7. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 226 – INFORMATION REQUESTED FROM THE BILLING/RENDERING PROVIDER WAS NOT PROVIDED OR WAS INSUFFICIENT OR INCOMPLETE.
   - 612 – NO PAYMENT IS MADE AS MEDICARE USES ANOTHER CODE FOR REPORTING AND/OR PAYMENT OF THIS SERVICE.
   - 612 – NO PAYMENT IS MADE AS MEDICARE USES ANOTHER CODE FOR REPORTING AND/OR PAYMENT OF THIS SERVICE. SUBMIT CORRECTIONS W/I 95 DAYS FROM DOS.
   - W3 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
   - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
   - 350 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
   - 724 – NO ADDITIONAL REIMBURSEMENT AFTER A RECONSIDERATION OF SERVICES. FOR INFORMATION CALL 1-800-937-6824

Issues

1. Did the insurance carrier appropriately request additional documentation?
2. Did the respondent support denial of payment on the grounds that Medicare requires the use of another code?
3. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code 226 – "INFORMATION REQUESTED FROM THE BILLING/RENDERING PROVIDER WAS NOT PROVIDED OR WAS INSUFFICIENT OR INCOMPLETE." The respondent did not provide documentation of the insurance carrier's request for additional information to process the medical bill. The procedure for an insurance carrier to request documentation not otherwise required upon submission of a bill is specified in §133.210(d) as follows:

   Any request by the insurance carrier for additional documentation to process a medical bill shall:
   (1) be in writing;
   (2) be specific to the bill or the bill's related episode of care;
   (3) describe with specificity the clinical and other information to be included in the response;
   (4) be relevant and necessary for the resolution of the bill;
   (5) be for information that is contained in or in the process of being incorporated into the injured employee's medical or billing record maintained by the health care provider;
   (6) indicate the specific reason for which the insurance carrier is requesting the information; and
   (7) include a copy of the medical bill for which the insurance carrier is requesting the additional documentation.

   No documentation was found to support that the insurance carrier made an appropriate request for additional information with the specificity required by §133.210(d). The Division therefore concludes that the insurance carrier failed to meet the requirements of §133.210(d). Accordingly, this denial reason is not supported.

2. The insurance carrier denied disputed services with claim adjustment reason code 612 – "NO PAYMENT IS MADE AS MEDICARE USES ANOTHER CODE FOR REPORTING AND/OR PAYMENT OF THIS SERVICE. SUBMIT CORRECTIONS W/I 95 DAYS FROM DOS."

   28 Texas Administrative Code §133.10(f)(1) sets out the data content and elements required for a complete professional or noninstitutional medical bill. Subparagraph (Q) requires that field 24D of the CMS-1500 form contain a "procedure/modifier code." Review of the medical bill finds that field 24D contains procedure code A0998 with modifier SS. Procedure code A0998 was a current HCPCS code at the time of service indicating ambulance response and treatment without transport to another site. The Division finds that the medical bill meets the requirements of §133.10.

   28 Texas Administrative Code §133.20(c) requires that "A health care provider shall include correct billing codes from the applicable Division fee guidelines in effect on the date(s) of service when submitting medical bills." There is no applicable Division fee guideline for ambulance services, therefore these services are reimbursed under the general medical reimbursement provisions of 28 Texas Administrative Code §134.1. Rule 134.1 does not refer to Medicare payment policies or to the Centers for Medicare and Medicaid Services (CMS). No documentation was presented to support that Medicare payment policies should apply to ambulance services. Therefore, the Division concludes that the medical bill meets the requirements of §133.20(c).

   This payment denial reason is not supported. The disputed services will therefore be considered for reimbursement according to applicable Division rules.

3. The services in dispute are ambulance transportation services for which the Division has not established a medical fee guideline. No documentation was found to support a negotiated contract between the parties or that the health care was provided through a workers' compensation health care network. Reimbursement is therefore subject to the general medical reimbursement provisions of 28 Texas Administrative Code §134.1(e), which requires that in the absence of an applicable fee guideline or a negotiated contract, medical reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with a fair and reasonable reimbursement amount as specified in §134.1(f).

   28 Texas Administrative Code §134.1(f) requires that:

   > Fair and reasonable reimbursement shall:
   > (1) be consistent with the criteria of Labor Code §413.011;
   > (2) ensure that similar procedures provided in similar circumstances receive similar reimbursement; and
   > (3) be based on nationally recognized published studies, published Division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available.

   The Texas Supreme Court has summarized the statutory standards and criteria applicable to "fair and reasonable" fee determinations as requiring "methodologies that determine fair and reasonable medical fees, ensure quality medical care to injured workers, and achieve effective cost control." *Texas Workers' Compensation Commission v. Patient Advocates of Texas*, 136 *South Western Reporter Third* 643, 656 (Texas 2004).

   Additionally, the Third Court of Appeals has held, in *All Saints Health System v. Texas Workers' Compensation Commission*, 125 *South Western Reporter Third* 96, 104 (Texas Appeals – Austin 2003, petition for review denied), that "each . . . reimbursement should be evaluated according to [Texas Labor Code] section 413.011(d)'s definition of 'fair and reasonable' fee guidelines as implemented by Rule 134.1 for case-by-case determinations."

   Texas Labor Code §413.011(d) requires that:

   > Fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. The commissioner shall consider the increased security of payment afforded by this subtitle in establishing the fee guidelines.

   28 Texas Administrative Code §133.307(c)(2)(O), requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 . . . when the dispute involves health care for which the division has not established a maximum allowable reimbursement (MAR) or reimbursement rate, as applicable."

   Review of the submitted documentation finds that:

   - The requestor has not articulated a methodology under which fair and reasonable reimbursement should be calculated.
   - The requestor does not discuss or explain how payment of the amount sought would result in a fair and reasonable reimbursement for the services in dispute.
   - The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in dispute.
   - The requestor did not submit nationally recognized published studies, published Division medical dispute decisions, or values assigned for services involving similar work and resource commitments (if available) to support the requested reimbursement.
   - The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

   The request for additional reimbursement is not supported. Thorough review of the submitted documentation finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the Division is to adjudicate the payment, given the relevant statutory provisions and Division rules. The Division would like to emphasize that the outcome of this medical fee dispute relied upon the evidence presented by the requestor and the respondent. Even though all the evidence was not discussed, it was considered.

For the reasons stated above, the Division finds that the requestor has failed to establish that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	April 15, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.